



Pre-Assessment Patient Questionnaire

Please fill out as much of this questionnaire as possible. This information will help your physical therapist to better understand your problems(s) and develop a treatment program that will best meet your needs.

Name: _____ Date: _____

Age: _____ Sex (Circle One) : Female Male

Are you a previous patient of APT? (Circle One): No Yes Problem: _____ Month/Year: _____

Are you being seen for physical therapy due to an accident? _____ When? _____

Whom can we thank for referring you to our clinic? _____

Please Answer the following questions about your JOB/ACTIVITY STATUS:

Previous to this injury my NORMAL job/activity status was (Circle as many as apply):

- Part-time Full-time WORKER at _____ company with job title of _____
- Part-time Full-time HOMEMAKER and/or RETIRED
- Primary Secondary CARETAKER of children ages _____
- Part-time Full-time _____ STUDENT

Are you currently off work because of your problem? (Circle One): Yes No

My functional limitations include: _____

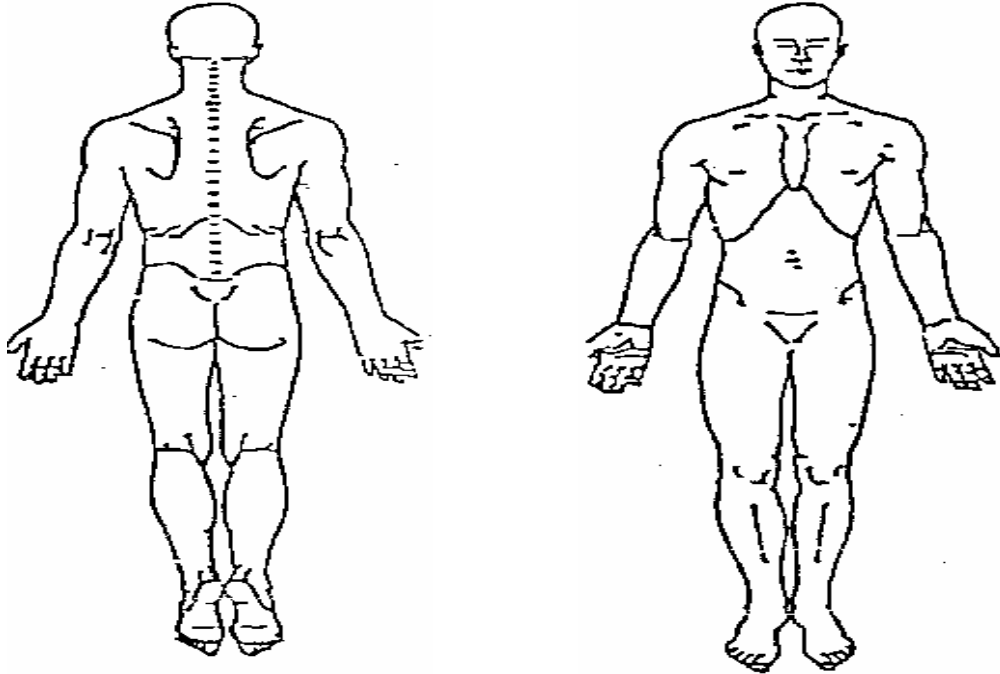
Injury and Functional Status Information

What is your MAIN PROBLEM/REASON for coming to physical therapy? _____

Approximately how long have you had the problem that has brought you in today? _____

Describe HOW this injury occurred: _____

Please mark the body diagrams below WITH X's for the areas that are currently bothering you.



Please rate your major area of pain on a scale of 0 to 10 by writing the number of you pain that corresponds to the appropriate word descriptors at the present time, as well as your best and worst over the past 30 days.

| | | | | | | |
|----------------|------------------|-----------------|---------------|--------------------|--------------------------|-----------------------|
| <u>No pain</u> | <u>Weak Pain</u> | <u>Moderate</u> | <u>Strong</u> | <u>Very Strong</u> | <u>Very, Very Strong</u> | <u>Emergency Room</u> |
| 0 | 1-2 | 3-4 | 5 | 6-7 | 8-9 | 10 |

Please Complete the following statements regarding your **CURRENT COMPLAINT**:

▪ I have pain in my (*area of body*): _____ which is typically
 (*Circle max of 2*): *Shooting* *Burning* *Aching* *Dull* *Other:* _____

▪ My problem includes:

Numbness in my: _____
Tingling in my: _____
Weakness in my: _____
Headaches occurring: _____

▪ Are your symptoms present **ALL** of the time or are there periods of time when you do not feel your symptoms at all?
 (*Circle One*) All of the time Come and go

▪ These specific activities or positions **INCREASE** my pain: _____

▪ These specific activities or positions **DECREASE** my pain: _____

- | | |
|---|-------------------|
| | Circle One |
| ▪ Do your symptoms disturb your sleep: | Yes No |
| ▪ Do your symptoms increase when you cough, sneeze or strain? | Yes No |
| ▪ Since your problem started, have you experienced any loss of bowel or bladder function? | Yes No |
| ▪ Since your problem started, have you experienced any unexplained weight loss? | Yes No |
| ▪ Is your pain worse at night? | Yes No |
- What treatments have you had for this problem? _____
-
- Describe PREVIOUS INJURIES you have had in this area: _____
-
- What tests have you had done for your problem? (Circle as many as apply): X-rays CT Scan MRI
- What were the results? _____

Patient History & Physical Condition Information

Please mark the appropriate 'YES' line(s) and give details only if not addressed above
YES

DETAILS

- | | |
|---|-------|
| _____ Do you have any infectious diseases (AIDS/HIV, Hepatitis, MRSA, etc.) | _____ |
| _____ Do you have a metal implant or pacemaker in your body? | _____ |
| _____ Are you pregnant? If so, how many weeks? | _____ |
| _____ Have you had organ removal or transplant surgery? | _____ |
| _____ Have you been diagnosed with cancer in any area? | _____ |
| _____ Is your general health status poor? | _____ |
| _____ Are you severely depressed? | _____ |
| _____ Do you consume alcohol? If so, how much? | _____ |

Do you have irregularities of the following systems?

- | | |
|--|-------|
| _____ Head, ears, nose or throat | _____ |
| _____ Lungs (asthma, emphysema, bronchitis) | _____ |
| _____ Heart (high blood pressure, MI, etc.) | _____ |
| _____ Circulation (blood clots, poor circulation, etc.) | _____ |
| _____ Gastrointestinal (Ulcers, acid reflux disease, etc.) | _____ |
| _____ Eyes (including recent change in visual acuity) | _____ |
| _____ Genitourinary (kidney stones, incontinence etc.) | _____ |
| _____ Musculoskeletal (fractures, sprains, arthritis, etc.) | _____ |
| _____ Neuromuscular (weakness, numbness etc.) | _____ |
| _____ Neurological (stroke, Parkinson's, seizures, MS, etc.) | _____ |
| _____ Metabolic/endocrine (thyroid, diabetes, etc.) | _____ |
| _____ Skin (rashes, etc.) | _____ |
| _____ Dental (TMJ, etc.) | _____ |

Are you a smoker? (Circle One) No Yes Packs per day _____ Number of Years _____

List All Current and Recent Medications

| Drug Name | Using Now Y/N | Benefit/Side Effects | Dr who prescribed meds | Phone Number of doctor |
|-----------|------------------|----------------------|------------------------|------------------------|
| | Y/N | | | |
| | Y/N | | | |
| | Y/N | | | |
| | Y/N | | | |
| | Y/N | | | |
| | Y/N | | | |
| | Y/N | | | |
| | Y/N | | | |
| | Y/N | | | |

PATIENT GOALS

What ONE or TWO problems would you like your therapist to address within the first 2 WEEKS of therapy (*your SHORT-TERM goals*)? _____

What ONE or TWO problems would you like your therapist to address within the first 4 to 6 WEEKS of therapy (*your LONG-TERM goals*)? _____

In order to get better, you will be expected to participate in your treatment. This may include doing exercises or avoiding certain activities. How committed are you to participating in your treatment? (*Circle One*)

Very committed

Somewhat committed

Not very committed

Are there any reasons that may limit your ability to participate in your treatment? (*Circle One*): Yes No

When finished, please sign and date this form. It will be placed in your chart and your therapist will discuss your answers with you. Thank you.

Signature: _____

Date: _____